

FILED SEP 12 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27605

State File No.

3263

Registrar's No.

Registration District No.

Primary Registration District No.

1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Trinity Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community 2 Days
years, months or days

3. (a) PRINT
FULL NAME

RALPH FRERKING

3. (b) If veteran,

name war No

3. (c) Social Security

No. 486-09-9938

4. Sex m
Color or race w

5. Color or

6. (a) Single, widowed, married,
divorced married

6. (b) Name of husband or wife
Clara K. Frerking

6. (c) Age of husband or wife if
alive 37 years

7. Birth date of deceased
August 17 1898
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

43

13

hr. min.

9. Birthplace

Lafayette Co., Mo.

(City, town, or county)

(State or foreign country)

10. Usual occupation

Engineer

11. Industry or business

P.C. Powers Light Co

12. Name

E. O. Frerking

13. Birthplace

Lafayette Co., Mo.

(City, town, or county)

(State or foreign country)

14. Maiden name

Sophia Scharnhorst

15. Birthplace

Lafayette Co., Mo.

(City, town, or county)

(State or foreign country)

16. (a) Informant

Trinity Lutheran Hospital

(b) Address

K. C. Mo

17. (a) Removal

(Burial, cremation, or removal)

(b) Date thereof

8-31-41

(Month) (Day) (Year)

(c) Place: burial or cremation

Sweet Springs, Mo.

18. (a) Signature of funeral director

W. J. Blackburn

(b) Address

931 1/2 E. 1st

19. (a)

8/31/41

(b)

M. M. Crowe

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline
(c) City or town Sweet Springs
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 30 year 1941
hour _____ minute _____

21. I hereby certify that I attended deceased from _____
that I am a _____
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

Death by electrocution

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 8-28-41
(c) Where did injury occur? Blackburn
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work

23. Signature W. J. Blackburn (M. D. or other)
Address K. C. Mo. Date signed _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. H. Blackman

Licensed Embalmer No. *3639*

P. O. Address *K. C. Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.